Patient Information Form

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

PATIENT INFORMATION FORM

Inquiry # or name
(e.g. CI 08-005, Cameron)

_____

This form is being given to you as the first step in exploring a concern regarding cancer or benign tumors of the brain and central nervous system (CNS) in your community. The person that gave it to you will explain the nature of the concern. The fact that you were given this form does not mean that there is a known problem in your community. It simply means that the person who gave it to you would like the Missouri Department of Health and Senior Services (DHSS) to look at information from those with cancer or benign brain and CNS tumors in the community to determine if there may be a problem. Your information will be kept confidential, and **will not** be shared with the person who gave you the form. For questions about the process please call (573) 522-2841.

Please print and fill in all of the information as completely as possible for you, if you are the individual with cancer or a benign brain or CNS tumor, or for your family member who had cancer or a benign brain or CNS tumor but is no longer living. At a minimum you should include legal name, birth date, social security number, how long you lived in the area (community of concern), and where you were diagnosed with cancer (name of hospital, physician or clinic). This information allows the DHSS to confirm the information and use it to look into the concern. If additional space is needed, use the back of the form or attach a separate sheet of paper.

Legal Name (Last Name, First Name, Middle Initial)	
☐ Male ☐ Female	Social Security Number ☐☐☐-☐☐-☐☐☐☐
Current Address (Street / City / State / Zip)	
Phone Number (☐☐☐)☐☐☐-☐☐☐☐	County
Birth Date (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐	Death Date (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐
Type of Cancer:	Date of Diagnosis (mm/dd/yyyy) ☐☐/☐☐/☐☐☐☐
Address at Time of Diagnosis (street, city, state, zip and **county**)	
Physician's Name	Facility name where you (or your family member) were first diagnosed with cancer. (Hospital or other facility)
Address when environmental exposure may have occurred (include street, city, state, zip and **county**) (For example, the address where you or your family member lived as a teen.)	
Number of years you or your family member lived at the address where exposure may have occurred.	☐☐
Do you currently smoke? ☐ **Yes** ☐ **No**	If you don't smoke now, what year did you quit smoking? ☐☐☐☐
Did you ever smoke? ☐ **Yes** ☐ **No**	How long did you smoke? ☐☐ Years
Additional Information & Comments: (Please feel free to provide additional information in this section or on the back. For example, maiden names, previous names used, if any. Information about you or your family member's occupation, exposure, etc.)	

Person Completing Form (if other than patient): _____

Relationship to patient: _____

Phone Number: _____ Is patient aware of this form? __Yes __No

Please return within 6 weeks of receipt to:

Bureau of Cancer and Chronic Disease and Control, Cancer Inquire Program
Missouri Department of Health & Senior Services
P.O. Box 570, Jefferson City MO 65102-0570

OR via fax (573) 522-2899
OR (573) 522-2898